b. The direct care staffing ratios calculated in subsection a above are ranked from high to low.

3. The DCSA shall be calculated as follows:

a. The total annualized Medicaid days for participating providers is projected from the six-month reporting period in Section 1a above.

b. The annualized Medicaid days are multiplied by a $0.50 minimum add-on to determine the minimum amount that a provider will receive. The total minimum add-on amount for all providers is calculated.

c. The remaining amount to be allocated is calculated by subtracting the total minimum add-on calculated in subsection b above from the total amount of the DCSA.

d. All providers with a direct care staffing ratio of 5 or above will be assigned the value of 5 and will only receive the minimum amount in subsection b above.

e. All providers with a direct care staffing ratio of 2.3 or below will be assigned the value of 2.3 and will receive the maximum add-on amount available under this methodology.

f. To achieve an inversely proportionate distribution, each provider's staffing ratio is subtracted from the assigned value of 5, from subsection d above, to calculate an inverted hours per patient day. This results in providers with a lower staffing ratio receiving a higher result (e.g., 5-2.3=2.7) and providers with a higher staffing ratio receiving a lower result (e.g., 5-5=0).

g. For each provider, the Medicaid patient days are multiplied by the inverted hours per patient day as calculated in subsection f above, to arrive at a unadjusted additional add-on amount.

h. The amount calculated in subsection g above for each provider is adjusted proportionately so that the total amount for all providers equals the remaining amount to be allocated in subsection c above.

i. Each provider receives a total DCSA which includes the minimum amount in subsection b above plus the remaining amount in subsection h above.

j. No changes or corrections to the data used to calculate the DCSA shall be made subsequent to the effective date of the DCSA except as noted in sections 4 and 5 below.

4. All providers receiving a DCSA must provide documentation of direct care expenditures during the period May 1, 2000 through October 31, 2000 to demonstrate adherence to legislative intent. This documentation must be submitted to the Agency by November 30, 2000 and in a format similar to the base data period documentation. Any amount deemed not to have been appropriately expended is to be reimbursed back to the Agency.

5. When prospective rates are based on cost reports that include any of the additional costs associated with the DCSA, an appropriate adjustment to the patient care component of the per diem rate shall be made to prevent duplicative reimbursement.

I. Medicaid Nursing Home Upper Payment Limit

The Special Medicaid Payments for nursing homes will be made in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each public, non-state government owned nursing home, the amount that would have been paid under Medicare payment principles for the previous year will be calculated and compared to what payments were actually made by Medicaid during that same time period. The calculation may then be used to make payments for the current year to nursing homes eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to the difference between Medicaid payments and 100 percent of what would have been paid under Medicare

payment principles may be paid to public, non-state government owned or operated nursing homes in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Florida Legislature. No payments under the Medicaid upper payment limit are being made to State government-owned or operated facilities or privately owned and operated facilities. For purposes of this section, Medicare payment principles refer to Medicare principles of cost reimbursement and the Medicaid upper payment limit will be established using Medicare principles of cost reimbursement.

J. Special Medicaid Payments

The following formula, except as noted below, shall be used to make Special Medicaid Payments (SMPs) to public non-state nursing facilities.

SMP = [A(Beds) + B(Cost)]/2

Where:

SMP = Special Medicaid Payment

A(Beds)=Allocation Based on Individual Nursing Facility Beds

A(Beds)=TAUPL*INFB/TNFB

Where:

TAUPL = Total Available Upper Payment Limit

INFB = Individual Nursing Facility Beds (for all public non state nursing facilities being paid under this formula).

TNFB = Total number of beds for all public non-state nursing facilities being paid under this formula

B(Cost) = Allocation Based on Individual Nursing Facility Costs

B(Cost) = TAUPL *FUPLA/TFUPLA

Where:

FUPLA = Facility Upper Payment Limit for Allocation (for all public non state nursing facilitues being paid under this formula).

TFUPLA = Total of Facility Upper Payment Limit for Allocation (for all public non state nursing facilities being paid under this formula).

For those nursing facilities where the Medicaid per diem rate is greater than 95% of the facility's Medicaid per diem cost, the nursing facility shall receive a SMP of $200,000. For nursing facilities paid under this provision will not have their beds included in the formula listed above. The Agency shall use the nursing facility's Medicaid per diem costs and Medicaid rate that were effective for the January 1 rate semester.

VI. Payment Assurance

The State shall pay each nursing home for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59, F.A.C., 42 CFR (1997), and Section 1902 of the Social Security Act. The payment amount shall be determined for each nursing home according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of nursing homes in the Medicaid Program, the availability of high-quality nursing home services for recipients, and for services, which are comparable to those available to the general public.

VIII. Payment in Full

Any provider participating in the Florida Medicaid nursing home program who knowingly and willfully charges, for any service provided to the patient under the State plan, money or other consideration in excess of the rates established by the State plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious

or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility or intermediate care facility; or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15 (1997).

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

Agency for Health Care Administration: (AHCA), also known as the Agency.

Audit: Means a direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

Audit Adjustment: Means any adjustment within the Medicaid audit report or Medicaid desk review report on Attachment A.

Audit Finding: Means any adjustment within the Medicaid audit report or Medicaid desk review report not listed on Attachment A.

Desk Review: Means an examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from the AHCA reviewer's office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

District: The agency shall plan and administer its programs of health, social, and rehabilitative services through service districts and subdistricts composed of the following counties:

District 1 - Escambia, Santa Rosa, Okaloosa, and Walton counties

District 2, Subdistrict A - Holmes, Washington, Bay, Jackson, Franklin, and Gulf counties

District 2, Subdistrict B - Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor counties

District 3, Subdistrict A - Hamilton, Suwanee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, and Alachua counties

District 3, Subdistrict B - Marion, Citrus, Hernando, Sumter, and Lake counties

District 4, Subdistrict A - Baker, Nassau, Duval, Clay, and St. Johns counties

District 4, Subdistrict B - Flagler and Volusia counties

District 5 - Pasco and Pinellas counties

District 6, Subdistrict A - Hillsborough and Manatee counties

District 6, Subdistrict B- Polk, Hardee and Highlands counties

District 7, Subdistrict A - Seminole, Orange, and Osceola counties

District 7, Subdistrict B - Brevard county

District 8, Subdistrict A - Sarasota and Desoto counties

District 8, Subdistrict B - Charlotte, Lee, Glades, Hendry and Collier counties

District 9 - Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach counties

District 10 - Broward county and

District 11 - Dade and Monroe counties

CMS-PUB.15-1: Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

Medicaid Interim Reimbursement Rate: A reimbursement rate or component of an overall reimbursement rate that is calculated from budgeted cost data. Any overpayments or under payments resulting from the difference between budgeted costs and actual costs (limited by class or statewide ceilings), as determined through an audit of the same reporting period, will be either refunded to the Agency or paid to the provider as appropriate.

Medically Fragile: Infants and children with complex medical problems are individuals, ages 0-21, who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hour a day medical/nursing/health supervision or intervention. Medically fragile means an individual whose medical condition is such that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN) or is ventilator dependent.

Medicaid Nursing Home Operating Costs: Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

Medicaid Nursing Home Patient Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

Medicaid Nursing Home Property Costs: Those costs related to the ownership or leasing of a nursing home. Such costs may include property taxes, insurance, interest and depreciation, or rent.

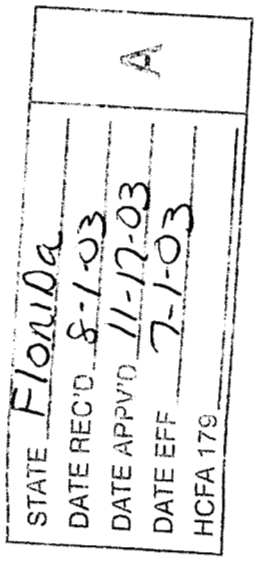
Provider: Means a person or entity licensed and/or certified under State law to deliver health care or related services, which services are reimbursable under the Florida Medicaid Program.

Reimbursement Ceilings: The upper rate limits for Medicaid nursing home operating and patient care reimbursement for nursing homes in a specified reimbursement class, or, the upper limit for nursing home property cost reimbursement for all nursing homes statewide.

Reimbursement Ceiling Period: January 1 through June 30 of a given year or July 1 through December 31 of a given year.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i).



APPENDIX A
CALCULATION OF THE FLORIDA NURSING HOME COST INFLATION INDEX

Based on a sample size of approximately 25% of the cost reports filed for the rate period beginning January 1, 1988, the percentage weights for cost components are estimated as:

Salaries and Benefits	57.89%
Dietary	5.18%
Others	36.93%

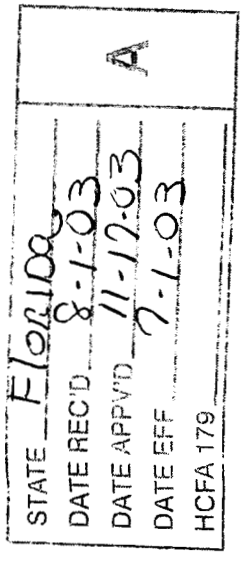
An inflation index for each of these components is developed from the Data Resources, Inc. Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

Component	DRI Index
Salaries and Benefits	Wages and Salaries, combined with Employee Benefits
Dietary	Food
All Others	Fuel and Utilities, combined with Other Expenses

The DRI indices are combined by summing the products of each index times the ratio of the respective DRI budget share to total budget share represented by the combined indices. Example: For the fourth quarter of 1982 Health Care Costs (April, 1982 issue, p. 18)

Wages and Salaries index = 1.026; budget share = .595
Employee Benefits index = 1.062; budget share = .089
Weighted combination (Salaries and Benefits)
= (1.026 x (.595/(.595+.089))) + (1.062 x (.089/(.595+.089)))
= 1.03068

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is utilized to obtain monthly indices called the Florida Nursing Home Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:



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Quarter	Index	Average Index	Corresponding Month
1982: 1	0.9908	0.9954	March 31
1982: 2	1.0000	1.0078	June 30
1982: 3	1.0155	1.0236	September 30
1982: 4	1.0316		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.0078/.9954)$^{1/3}$ x .9954
= .9995

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.0078/.9954)$^{2/3}$ x .9954
= 1.0036

All monthly indices can be calculated in a similar fashion.

These indices will be updated semi-annually prior to each January 1 and July 1. Weights for cost components will be updated based on the latest available cost data on file with AHCA.

APPENDIX B
CALCULATION OF THE FLORIDA CONSTRUCTION COST INFLATION INDEX
FOR RATES EFFECTIVE PRIOR TO 7/1/91

The Florida Construction Cost Inflation Index is calculated by combining certain indices in the semiannual quarterly publication, Dodge Building Cost Indices for U.S. & Canadian Cities, published by McGraw-Hill. The Florida Index is calculated by the following steps:

1. Compute the average Dodge Index for the six Florida cities listed in the publication: Fort Myers, Jacksonville, Miami, Orlando, Tallahassee, and Tampa.

2. The combined Florida Construction Cost Inflation Index from Step 1 is projected one semester forward by assuming that the change in the index over the six months will equal the change in the last six months. Thus:

   Projected Index Value =
   $$\frac{\text{Last Index Value}}{\text{Next-to-last Index Value}} \times \text{Last Index Value}$$

   For example, the March 1984 average value is 1700.02 and the September 1983 average value is 1688.27 (using the March 1984 publication), so that:

   $$\text{Projected March 1984 value} = \frac{1700.02}{1688.27} \times (1700.02) = 1711.85$$

3. The semiannual index values obtained in Steps 1 and 2 are used to obtain monthly Florida Construction Cost Index values. The monthly index value m months past the previous index is computed as follows:

   $$\text{Monthly Value m Months Past Previous Index} = \left(\frac{\text{Next Index Value}}{\text{Previous Index Value}}\right)^{m/6} \times \text{Previous Index Value}$$

   For example, using the September 1983 and March 1984 values given above, the interpolation formula yields

   $$\text{October 1983 Index} = \left(\frac{1700.02}{1688.27}\right)^{1/6} \times 1688.27 = 1690.22$$

   $$\text{November 1983 Index} = \left(\frac{1700.02}{1688.27}\right)^{2/6} \times 1688.27 = 1692.17$$

These indices will be updated semi-annually prior to each January 1 and July 1 using the most recent publication of the Dodge Indices.

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FOR RATES EFFECTIVE ON AND AFTER 7/1/91

The Florida Construction Cost Inflation Index is calculated from Health Care Costs published by DRI/McGraw-Hill using the CPI All Urban All Items Regional Index for the South Region. The Florida Index is calculated by the following steps:

1. Using the most recent Health Care Costs publication, locate the tables containing the Consumer Price Index All Urban All Items.

2. Using the South Region, divide the index corresponding to the midpoint of the current rate period by the index of the midpoint of the previous rate period. The results shall be the inflation multiplier for the rate semester.

Example:

Rate Semester - January 1991

Publication - DRI/McGraw-Hill Health Care Costs, Third Quarter 1990, Page 18, Table 6.

Quarter Index		Average Index	Corresponding Month
1991:2	1.041	1.0345	March 31
1991:1	1.028		
1990:4	1.014	1.007	September 30
1990:3	1.000		

6 month inflation multiplier =
(1.0345/1.007) =
1.027308 or
2.7308 % increase over 6 months.

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